General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Touchwood Pharmacy, 84a London Lane, BROMLEY, Kent, BR1 4HE

Pharmacy reference: 1032619

Type of pharmacy: Community

Date of inspection: 14/11/2022

Pharmacy context

This is a community pharmacy in a largely residential area and near a main road. It is close to a medical surgery. The pharmacy provides NHS dispensing services as well as travel and flu vaccinations. It supplies medication in multi-compartment compliance packs to some people who need help taking their medicines. The pharmacy has recently had a refit which has increased the size of the dispensary.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages the risks associated with its services. It generally keeps the records it needs to. People can provide feedback about the pharmacy's services. And staff know how to protect the welfare of a vulnerable person. The pharmacy largely protects people's personal information appropriately. When a dispensing mistake happens, staff generally respond well. But they do not always record mistakes that happen properly, which could mean that they are missing out on opportunities to make the pharmacy's services safer.

Inspector's evidence

The pharmacy had recently received a refit, and the team members described how this had created additional pressure for them while it was being finished. There were still some maintenance issues which were being addressed. And the refit had affected some of the team's access to the pharmacy's electronic systems and not all the paper records could be located during the inspection.

The pharmacy had electronic standard operating procedures (SOPs) which had been prepared by the pharmacy's head office. Staff had access to them on the pharmacy's computer. But there were some problems with the access to this system following on from the recent refit. The responsible pharmacist (RP) explained that his access to the system had recently changed. Although he could show which SOPs he had read through, he was currently not able to show which ones the other team members had been through. Some other team members confirmed that they had read the relevant SOPs, but not all of them had done this. The RP said that he would ensure they were given time to read through the SOPs relevant to their roles.

The medicines counter assistant (MCA) could describe her own role and responsibilities. And she could explain what she could and could not do if the pharmacist had not turned up in the morning.

Dispensing mistakes that were identified before the medicine was handed to a person (near misses) could be recorded on the pharmacy computer system. But there were only one or two near misses which had been recorded over the previous few months. The RP accepted that it was likely that some more near misses had occurred in this time. He explained that access to the computer system had been affected by the refit, and said that he would review how the near misses were recorded in the future. The RP described how any dispensing mistakes where the medicine had been handed to a person (dispensing errors) were recorded. But the errors were recorded as near misses on the computer system, which could mean that all the relevant information may not be recorded. The RP said that he would review how the pharmacy recorded any dispensing errors. He gave an example of an incident where a person's name had not been checked when the medicine had been handed out, and as a result he had spoken with the team about it.

The pharmacy had a complaint policy. There were different ways in which people could make a complaint or provide feedback, such as in person, or via the company's website. The pharmacy had previously had a sign in the public area to explain to people how they could provide feedback, but this had been removed during the refit. The RP said that he would obtain another sign.

The pharmacy had current indemnity insurance. The right RP notice was displayed to the public, and the

RP record had been filled in. Some records of private prescriptions dispensed were missing the prescriber's details, and some emergency supply records did not indicate the nature of the emergency. This could make it harder for the pharmacy to find out these details if there was a future query. The controlled drug (CD) registers were held electronically, and the samples seen complied with requirements. A random check of a CD medicine showed that the physical quantity matched the balance showed in the register. Staff were unable to locate records of unlicensed medicines dispensed, and said that this was due to the paperwork having been moved during the refit.

No confidential information could be read from the public area. There were bags of medicines awaiting collection, but these were placed sufficiently far back so that people's details could not be seen. Confidential waste was placed into a designated bin and not into general waste. Some staff had smartcards to access the NHS electronic systems, but not all the staff who needed to access the system had a working card. This meant that there was some sharing of cards when a staff member finished their shift. The trainee pharmacist said that she did have a card and would look into getting it activated.

The RP confirmed that he had completed the level 2 safeguarding training and could explain what he would do if he had any concerns about a vulnerable person. Team members said that they would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do some ongoing training to help keeps their knowledge and skills up to date. And they feel comfortable about raising any concerns or making suggestions. They can take professional decisions to help keep people safe.

Inspector's evidence

At the time of the inspection there was the RP, a trained MCA, a trained accuracy checking technician (ACT), and a foundation year trainee pharmacist. The trainee pharmacist felt her training was going well, and the RP was her training supervisor. The MCA could describe what she would do if a person wanted to buy a medicine that could be misused, and she was seen referring queries to the RP as appropriate.

The RP described the impact that the pandemic had had on the team and that the pharmacy team had been under a lot of pressure. At the time of the inspection, staff were up to date with their workload and were observed communicating effectively with each other. Team members did some ongoing training to help keep their skills and knowledge up to date, and had access to online training modules. They were able to complete it at work during quieter times. The RP described how he updated the team about any new products or services as necessary. Staff felt comfortable about making suggestions or raising any concerns. And they were not set any numerical targets. The RP felt able to take professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services, and they are kept secure. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy's refit had increased the size of the dispensary and slightly decreased the size of the retail area. The dispensary had ample clear workspace and the pharmacy itself was clean and tidy. The pharmacy had a bright and professional appearance, and lighting was good throughout.

The pharmacy had a decent-sized consultation room, which provided an adequate level of soundproofing. The room was unlocked at the time of the inspection, which could make the items inside the room less secure. The room was locked when this was highlighted, and the RP gave an assurance that it would be kept locked when not in use. The premises were secure from unauthorised access when the pharmacy was closed.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. And people can access its services. It gets its medicines from reputable supplies and generally stores them properly. It does not highlight prescriptions for higher-risk medicines, so it may be missing out on opportunities to speak with people collecting these medicines.

Inspector's evidence

People accessed the pharmacy through a step-free entrance. They were able to book appointments for services such as vaccinations in person, on the phone, or online. The RP said that he reviewed the appointments that were booked in and checked that vaccine stock would be available. The pharmacy's computer system could generate large-print labels for people who needed them.

Prescriptions for higher-risk medicines such as warfarin or methotrexate were not routinely highlighted. This could mean that staff missed out on opportunities to talk with people collecting these medicines. Prescriptions for Schedule 4 CDs were not highlighted, which could make it harder for the team member to know if the prescription was still valid. The team was aware of the guidance about pregnancy prevention for people in the at-risk group who took valproate-containing medicines. The relevant warning cards were present on the original manufacturer's packs of valproate. But there were some split packs on the shelves and there were no additional warning cards or leaflets. The RP gave an assurance that more would be ordered from the manufacturer. He said that the pharmacy currently had no people who were in the at-risk group.

The pharmacy offered a range of travel vaccinations and was registered to provide Yellow Fever vaccinations. The RP showed the current patient group directions (PGDs) which were available electronically in the consultation room. The selection of PGDs seen were in date, and the RP described the training he had undertaken to be able to do the vaccinations.

The pharmacy dispensed medicines in multi-compartment compliance packs for some people. People were usually assessed to see if they needed the packs by the local NHS medicine optimisation service. Dispensed packs were initialled when they were dispensed and checked, to provide an audit trail. The packs were not labelled with descriptions of the tablets or capsules inside, and this could make it harder for people or their carers to identify the medicines. Patient information leaflets were not always supplied with the packs, which could mean that people may not have up to date information about how to take their medicines safely. The ACT showed how she kept a record of any changes to people's medicines and copies of people's hospital discharge notes. She gave an example of what she had done when a surgery issued a prescription for a medicine which had been discontinued by a hospital.

The RP described how an audit trail was kept to show when medicines had been delivered to people's homes. He believed that the driver had the records of this and said that he would review where these were kept to ensure that they were kept securely.

Medicines were ordered from licensed wholesalers and specials manufacturers, and were stored tidily in the dispensary. There was one loose strip of tablets in stock, and one box of medicines contained mixed batches. These were removed during the inspection. Bulk liquid medicines were not always

marked with the date of opening, which could make it harder for staff to know if they were still suitable to use. Stock was date checked regularly, and records about this were kept. No date-expired medicines were found in with stock when medicines were randomly checked. Medicines which required cold storage were kept in suitable fridges and the temperature ranges were recorded daily. At the time of the inspection the maximum temperature for the vaccine fridge was out of the appropriate range, but the previous records and the current temperature were within range. The RP said that he would ensure the fridge thermometer was reset when the temperatures were taken. Medicines that people had returned for destruction were separated from regular stock and put into designated bins and sacks. CDs were kept securely.

The pharmacy received drug alerts and recalls on its computer system. At the time of the inspection there was a backlog, and there were several alerts which had not been marked as actioned. However, when checked, these alerts did not relate to stock the pharmacy currently held. The RP explained that there had been problems accessing the system due to the refit, and said he would ensure they were kept more up to date in the future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had clean glass measures for measuring liquids accurately. There was a blood pressure meter in the consultation room, which had been obtained a few months ago. At the time of the inspection there was not an anaphylaxis kit in the consultation room but there was one in the dispensary. The RP moved the kit into the consultation room to provide easier access in an emergency. The phone was cordless and could be moved to a more private area to help protect people's personal information.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.